Chapter 1
General Information

INTRODUCTION

Your Benefits

Your benefits are a very important part of your compensation package. **Please read this Handbook carefully as it contains vital information about your benefits.** The Department of Central Management Services (CMS) is the agency that administers the health benefit of this program. The Teachers' Retirement System (TRS) is responsible for determining eligibility, enrollment and premium collection. Annually, you have the opportunity to review your choices and change your coverage for the plan year.

Where To Get Additional Information

- **Teachers' Retirement System**

  TRS can answer your enrollment, eligibility, premium collection and general benefits questions. They can be reached at:

  TRS
  2815 W. Washington, P.O. Box 19253
  Springfield, IL 62791
  (800) 877-7896
  TDD/TTY: (217) 753-0329

If TRS is unable to answer your questions, please refer to the following:

- **Plan Administrators.** Each individual plan administrator can provide you with specific information or coverage inclusions/exclusions. For a list of plan administrators, see Chapter 3, Section entitled Plan Administrators.
- **Annual Benefit Choice Options Booklet.** This Booklet contains the most current information regarding changes for the plan year. New benefits and changes in plan administrators are included in the Booklet. **Read this Booklet carefully as it contains important benefit information that may affect your coverage.**
- **The Illinois Department of Central Management Services.** The CMS Group Insurance Division can answer your benefit questions or refer you to the appropriate party for assistance. They can be reached at:

  CMS Group Insurance Division
  Room 600, Stratton Office Building
  Springfield, IL 62706
  (800) 442-1300 or (217) 782-2548
  TDD/TTY: (800) 526-0844

Change of Address

Important benefit information such as identification cards or other mailings are sent to you throughout the year. If you or any of your dependents have a change of address, notify TRS immediately. TRS will update the CMS insurance membership system and provide your address to all your plan administrators. For this reason, it is crucial that we have your current residence on file.

Life Changing Events

Certain changes in your personal life may affect your eligibility or your dependent's eligibility for benefits. **Therefore, it is important to keep TRS informed of any life changing events.** Refer to Chapter 1, Section entitled Enrollment for additional information.

Medicare Premium

In order to receive the Medicare Primary Premium, participants must be enrolled in both Medicare Parts A and B. If the participant is not enrolled in Medicare Parts A and B, the higher non-Medicare premium will be assessed.

ID Cards

The Plan Administrators produce ID cards at the time of enrollment and cards are mailed to the home address on file with TRS. To obtain additional cards, contact the plan administrator listed in Chapter 3 of this Handbook or the annual Benefit Choice Options Booklet.

HEALTH PLAN OVERVIEW

Depending on residence, there may be several types of health plans from which to choose. The offerings may change each year. Refer to the Benefit Choice Options Booklet for the current offerings.

Types of Health Plans

- **Indemnity Plan**

  Teachers' Choice Health Plan (TCHP)
- **Managed Care Plans**

  Health Maintenance Organization (HMO)

  Open Access (OAP) Plan

Each plan provides medical, pharmaceutical and mental health/substance abuse treatment benefits. However, the covered services, benefit levels, exclusions and restrictions on service providers differ.

In making choices, consider the following: health status, coverage needs and service preferences. Dependents must have the same health plan as the Participant under whom they are covered.

Indemnity Plan

TCHP, the traditional health plan, offers a comprehensive range of benefits.

Under the TCHP, plan participants are free to select any medical provider (physician, specialist or hospital) and change providers at any time. Benefit enhancements are available by utilizing Preferred Provider Organization (PPO) hospitals and physicians (for inpatient and outpatient services), the pharmacy network and mental health/substance abuse network providers. Transplant benefits are available through the Transplant Preferred Provider Organization (TPPO) Network. Call the Notification Administrator for answers to specific questions.

For detailed information about TCHP, see Chapter 2 entitled Teachers' Choice Health Plan.

Managed Care Plans

Over the years, as health care costs continue to rise, more and more employers offer managed healthcare plans. Individuals receiving medical care under a managed care plan are encouraged to have annual preventive physicals and seek early treatment if they become ill.

Managed care plans negotiate rates with participating network physicians, hospitals and pharmacies. In turn, the plans offer cost-effective medical care with lower out-of-pocket costs.

Managed care plans provide comprehensive medical benefits. Copayment amounts may vary among the plans offered. When considering a managed care plan, special attention should be directed to the participating physicians and hospitals which plan participants are required to use for maximum benefits.

HMO plan participants choose a doctor or provider location from those participating in the plan's provider network. This doctor or location becomes the primary care provider (PCP). HMO plans provide a comprehensive network for care. All routine medical care, hospitalizations and referrals for specialized medical care must be coordinated under the direction of the PCP. Services provided without approval/referral from a PCP will not be covered. Plan participants are responsible for 100% of the cost of out-of-network care. Coverage outside the HMO area is limited to emergency services only.

The Open Access Plan (OAP) allows plan participants to take advantage of a more comprehensive benefit plan without restricting the freedom to select a health care provider. The OAP features three benefit levels. The lowest out of pocket and highest level of benefit coverage is received when utilizing a Tier I provider. The mid-level of benefit coverage is received when utilizing a Tier II provider. Out-of-network benefits are also available. The level of benefits you receive is determined by the selection of care providers chosen. OAP participants must select a PCP from the Tier I or Tier II networks. Each covered family member may select a different PCP.

OAP participants can mix and match providers from different tiers. For example, you can utilize a Tier I hospital and a Tier II physician. In this example, the hospital would be paid at the Tier I benefit level and the physician at the Tier II benefit level.

The Tier I network offers a 100% benefit after a copayment. The Tier II network offers a 90% benefit after a deductible. The out-of network benefit is 80% of U&C after the deductible has been met. However, certain services such as preventive services, well baby care, skilled nursing care and transplants are covered **only** at Tier I or Tier II providers.

Managed care plans contract with a network of physicians and hospitals to deliver or arrange for the delivery of covered services. If the designated PCP leaves the managed care plan's network, there are three options:

- Choose another PCP with that plan;
- Change managed care plans; or
- Enroll in the TCHP.

The opportunity to change plans applies only to the PCP leaving the network. It does not apply to hospitals, specialists or women's healthcare providers who are not the designated PCP.

Participants are notified in writing to exercise one of the previous three options when a provider network change occurs.

- **Points to consider about managed care plans:**
  - There is little, if any, paperwork.
  - Managed care plans have restricted service areas. When traveling outside of the plan's service area, coverage is for emergency services only. For specific information regarding out-of-area services or emergencies, call the managed care plan.
  - The PCP selected from the list of participating physicians will coordinate all care.
  - Referrals for specialty care will be restricted to those services and providers authorized by the designated PCP. In some cases, referrals may also require pre-approval from the managed care plan.
  - The use of hospitals is restricted to those which are affiliated with that managed care plan and with which the designated PCP or approved specialist has admitting privileges.
  - Contact the plan administrator to determine the exact coverage for any services. Beyond the minimum level of coverage managed care plans are required to provide, there are differences in covered services and to what extent coverage is provided.
  - Use of pharmacies is restricted to those affiliated with each managed care plan. Mandatory generic and/or formulary restrictions may apply. Contact each managed care plan for specific information regarding coverage for prescription drugs.

For complete information on specific plan coverage or the provider network, contact the managed care plan and review the plan description and certificate of coverage.

NOTE: Managed care plan provider networks are subject to change. Always call the respective managed care plan for the most up-to-date information.

See Chapter 3, Section entitled Plan Administrators for a complete listing of managed care plan administrators.

ELIGIBILITY

This chapter contains benefit eligibility information which applies to all health plans.

Eligibility Requirements

Enrollment requirements are defined by the State Employees Group Insurance Act of 1971, as amended (5 ILCS 375/1 et seq.) or as hereafter amended, and by such policies, rules and regulations as shall be promulgated thereunder. Improper enrollment can cause many problems in both premium collection and reimbursement of medical expenses. If there is any change in enrollment information (family status, Medicare eligibility, or address) notify TRS immediately at 800-877-7896. Failure to notify TRS may result in loss of benefits.

Eligible As Benefit Recipient

To be eligible, annuitants must be receiving a monthly benefit or retirement annuity from TRS and have at least eight years of creditable service under Article 16 (TRS) of the Illinois Pension Code; or (I) have been enrolled in the health insurance program offered prior to January 1, 1996; or (II) be the Survivor of a Benefit Recipient who had at least eight years of creditable service under Article 16 (TRS) of the Illinois Pension Code; or (III) be a Survivor of a Benefit Recipient who was enrolled in the TRS program prior to January 1, 1996; or (IV) be a recipient of a TRS disability benefit.

Participants enrolled in one of the TRIP plans are not eligible for health coverage under the State Employees Group Insurance Program.

Eligible as a Dependent Beneficiary

- Eligible Dependent Beneficiaries include:
  - Spouse
  - Parents - If they are dependent upon the Benefit Recipient for more than one-half of their support and are claimed by the Benefit Recipient as a dependent for income tax purposes.
  - Unmarried child under age 19, including:
    - Natural child.
    - Adopted child.
    - Stepchild who lives with the Benefit Recipient in a parent-child relationship.
  - Unmarried child age 19 through 22, who meets **ALL** the following conditions:
    - Enrolled as a full-time student in an accredited school.
    - Financially dependent upon the Benefit Recipient.
    - Eligible to be claimed as a dependent for income tax purposes by the Benefit Recipient.
  - Unmarried child age 19 and older who is mentally or physically handicapped and meets **ALL** of the following conditions:
    - Financially dependent upon the Benefit Recipient.
    - Eligible to be claimed as a dependent for income tax purposes by the Benefit Recipient.
    - Continuously disabled from a cause originating prior to age 19.

ENROLLMENT

Enrollment Periods

- **There are instances when Benefit Recipients may enroll or change their benefit selections:**
  - Initial Enrollment.
  - Annual Benefit Choice Period (Initial enrollment only).
  - Qualifying Change in Status - Life changing events that may impact eligibility for you or your dependent(s).

Initial Enrollment

Benefit Recipients may initially enroll in TRIP when one or more of the following occurs:

- **Upon application of annuity benefits.** An enrollment card must be submitted no later than 30 days after the effective date of benefits. Coverage will be effective the first day of the first full month of benefits or the first of the month when the enrollment card is received, whichever is later. The effective date may be delayed up to 4 months. However, request for the delay must be received within the 30 day application period.
- **The Benefit Recipient or Dependent Beneficiary turns age 65.** The Benefit Recipient/Dependent Beneficiary has 6 months from the date they became eligible for Medicare to apply for coverage. If the Benefit Recipient/Dependent Beneficiary is Medicare ineligible, they have 30 days from their 65th birthday to apply for coverage. Coverage will be effective the first day of the month in which the Benefit Recipient reaches age 65, or when the enrollment card is received, whichever is later.
- **Coverage is terminated by a former group plan (Benefit Recipient and Dependent Beneficiary).** To enroll a Dependent Beneficiary under these circumstances, the Benefit Recipient must already be enrolled in TRIP. The Benefit Recipient has 30 days following the effective date of coverage termination to submit to TRS the enrollment card (enrolling the Benefit Recipient and eligible Dependent Beneficiary's) and letter from the terminating group plan. Termination of coverage must be initiated by the group plan. Termination for non-payment of premium does not qualify as loss of coverage by the group plan and therefore is not an eligible enrollment event.
- **Annual Benefit Choice Period.** Retired teachers who are eligible for, but have never enrolled in, one of the health plans under TRIP may do so during the Annual Benefit Choice period. However, this is not an opportunity to re-enroll.

Annual Benefit Choice Period

The annual Benefit Choice Period is normally held each May 1st through May 31st. During this 31-day period, a Participant may initiate action to change coverage elections. All health changes initiated during the annual Benefit Choice Period are effective on July 1st. During the annual Benefit Choice Period, plan participants may change health plans.

As required by the State's contractual obligations, coverage elected during the annual Benefit Choice Period remains in effect throughout the entire year, unless the Participant experiences a Qualifying Change in Status.

Qualifying Change in Status

Participants experiencing a Qualifying Change in Status have certain Benefit Choice options available for a specified time period. All mid-year changes must be consistent with the Qualifying Change in Status the Participant has experienced. **When an enrolled Participant experiences a Qualifying Change in Status, the Participant has 31 days from the date of that change to submit proper documentation to TRS.**

- **A Qualifying Change in Status has occurred when one or more of the following takes place:**
  - Marriage, divorce.
  - Birth/adoption of a child.

Consistency Rule

All mid-year changes in coverage be consistent with the Qualifying Change in Status event the Participant experiences.

Termination of Dependent Beneficiary Coverage

Dependent coverage may be terminated at any time upon written request. The change in coverage will be effective the first of the month following receipt of the request. Re-enrollment opportunities are limited. Call TRS for information.

Special Provisions

- **When both spouses are Benefit Recipients, the following applies:**
  - When both husband and wife are eligible as a Benefit Recipient, each may be enrolled as a Benefit Recipient. Either spouse may elect health coverage for the eligible Dependent Beneficiaries.
- **Dependent Beneficiary Enrollment:**
  - The Benefit Recipient and all covered Dependent Beneficiaries enrolled under that Benefit Recipient must be enrolled in the same health plan.
- **Documentation Requirements:**
  - The following documentation must be provided to enroll/recertify Dependent Beneficiaries in the Student, Handicapped or Parent categories:
    - **Student Category** – Verification of enrollment as a full-time student and a Dependent Coverage Certification Statement are required.

      If an active Dependent Beneficiary turns age 19 in June, July or August, verification of enrollment as a full-time student is not required. The Benefit Recipient will need to provide a Dependent Coverage Certification Statement indicating intent to enroll in the Fall. The Dependent Beneficiary will be required to provide documentation of enrollment during the Fall certification (see Recertification of Dependent Coverage).
    - **Handicapped Category** – Initial enrollments in the handicapped category require a diagnosis from a physician with an ICD-9 diagnosis code and a letter from the doctor detailing the Dependent Beneficiary's limitations, capabilities and onset of condition, and a statement from the Social Security Administration with the Social Security disability determination, if applicable, and a Dependent Coverage Certification Statement.

      Dependent Beneficiaries already enrolled in the handicapped category are only required to annually provide a Dependent Coverage Certification Statement. All **initial enrollments into the handicapped category** are subject to review and approval by TRS.
    - **Parent Catergory** – Verification that the parent is dependent upon the Benefit Recipient for more than half of their support and that the parent is claimed by the Benefit Recipient as a dependent for income tax purposes, and a Dependent Coverage Certification Statement is required.
- **Effective Date of Coverage as Student:**

  A **new Dependent Beneficiary** being added as a dependent in the student category does not become eligible for coverage until the first day of the month in which classes begin or the date coverage is requested, whichever is later.
- **Recertification of Dependent Beneficiary Coverage:**
  - **Annual/Semi-Annual Recertification**
    - **Student Category** – The Plan requires Benefit Recipients to recertify continued eligibility for Dependent Beneficiaries age 19 or older enrolled as students. Beginning July 1, 2000, recertifications are required twice per year; in the Fall and in the Spring. Failure to recertify a Dependent Beneficiary will result in the Dependent Beneficiary's coverage being terminated.
    - **Handicapped Category** – Annual recertification of Dependent Beneficiary's age 19 or older enrolled in the handicapped category is required. Failure to recertify a Dependent Beneficiary will result in the Dependent Beneficiary's coverage being terminated.
    - **Parent Catergory** – Annual recertification of Dependent Beneficiary's eligibility in the parent category is required. Failure to recertify the Dependent Beneficiary will result in the Dependent Beneficiary's coverage being terminated.
  - **Birth Date Recertification** – Benefit Recipients must verify continued eligibility for dependents turning age 19 (student) or 23 (handicapped). Benefit Recipients with a Dependent Beneficiary turning age 19 or 23 will receive a notification from TRS several weeks prior to the birth month that the Dependent Beneficiary must be recertified in order to continue coverage. The Benefit Recipient must provide the required documentation to TRS prior to the Dependent

Beneficiary's birth date. Failure to recertify the Dependent Beneficiary's eligibility will result in the Dependent Beneficiary's coverage being terminated effective the end of the birth month.

- **Reinstatement** – If coverage for the Dependent Beneficiary is terminated for failure to recertify and the Benefit Recipient provides the required documentation within 30 days from the date the termination is processed, coverage will be reinstated retroactive to the date of termination. If the documentation is not provided within the 30 day period, coverage will be reinstated effective the first of the month following the date the documentation is received by TRS, but not retroactive to the date of termination.

NOTE: Dependents of COBRA Benefit Recipients are also required to recertify eligibility for coverage.

Contact TRS for questions regarding recertification.

- **Retroactive Policy: Corrections to eligibility that result in a premium refund will only be processed retroactively up to six months, with six months adjustment on premium.** It is the Benefit Recipient's responsibility to immediately advise TRS of changes in eligibility for coverage under the Program including enrollment in Medicare. **Failure to notify TRS of changes in eligibility (including death) or errors in premium payments in a timely manner will result in application of the Retroactive Policy.** There are no exceptions to this policy.

  Membership changes for a Dependent Beneficiary who is determined ineligible, such as a divorced spouse, will be effective retroactive to the date the Dependent Beneficiary became ineligible.

- **Change in Residence:** Notify TRS immediately of any change in address. Residence determines plan availability through TRIP.

- **Change in Medicare Status:** If at anytime the Participant becomes eligible for or enrolls in Medicare, a copy of the Medicare card must be provided to TRS. Failure to do so may impact the premium paid and the benefits received.

- **Premiums:** The law requires that the premium be deducted from the annuity received by the Benefit Recipient. If the annuity is insufficient to cover the premium, a direct pay statement will be sent which requires monthly payments. Premium payment is required through the month of cancellation or death. Premium amounts and other updated information for each plan year will appear annually in your Benefit Choice Options Booklet. Review the booklet for premium amounts.

TERMINATION OF COVERAGE

This section describes the events and timing of the termination of benefits. In most cases, health coverage can be continued at the Benefit Recipient's expense for a limited period of time under federal law referred to as COBRA (Consolidated Omnibus Budget Reconciliation Act). If interested in continuing coverage under COBRA, review the requirements and deadlines for filing in the next section entitled COBRA Continuation of Coverage. TRS can help with any questions on the termination of benefits and how to apply for continuation of benefits under COBRA.

Termination of Benefit Recipient's Coverage

- **A Benefit Recipient's coverage terminates at midnight on the last day of the month when:**
  - Eligibility requirements are no longer met.
  - TRIP coverage terminates.
  - A written request is received by TRS that coverage should be terminated.
  - They become eligible for and enroll in the State of Illinois Employees Health Insurance Program.
  - Death.

NOTE: Immediately notify TRS of the annuitant's death. The TRS Survivor Benefit Department will send information to the Benefit Recipient's designated beneficiary. The completed enrollment application must be returned to TRS, along with the Survivor Benefit Option letter, within 30 days of the date of the letter. If coverage is elected, it will be reinstated retroactive to the date coverage was terminated as a Dependent Beneficiary, therefore, eliminating any lapse in coverage.

Termination of Dependent Beneficiary Coverage

- **An enrolled Dependent Beneficiary coverage terminates:**
  - Simultaneously with termination of a Benefit Recipient's coverage.
  - When coverage is terminated by the Benefit Recipient.
  - When the enrolled Dependent no longer meets eligibility requirements.
  - At midnight on the date of death.
- **A Dependent Beneficiary's coverage is terminated effective the end of the month the Dependent Beneficiary becomes 19 years of age, unless:**
  - The Dependent Beneficiary is enrolled as a full-time student, financially dependent upon the Benefit Recipient and eligible to be claimed for income tax purposes by the Benefit Recipient. In such cases, coverage terminates at midnight the last day of the month of graduation, cessation of studies, or age 23, whichever is earlier; or
  - The enrolled Dependent Beneficiary qualifies for coverage as a handicapped Dependent Beneficiary.

COBRA — CONTINUATION OF COVERAGE

Overview

COBRA (Consolidated Omnibus Budget Reconciliation Act) was signed into law on April 7, 1986, as P.L. 99272 and went into effect July 1, 1986. Under COBRA, TRS must provide covered Benefit Recipients and eligible Dependent Beneficiaries who lose coverage under the Program the option to continue coverage. The mandate is restricted to certain conditions under which coverage is lost, and the election to continue must be made within a specified election period.

COBRA Eligibility

Annuitants or survivors previously receiving an annuity, as well as the spouse and/or dependent children of any of these individuals who lose TRIP benefits due to certain qualifying events are considered "qualified beneficiaries" and may be eligible to continue coverage under provisions of COBRA. A child born to or placed for adoption with the covered person during a period of COBRA coverage can also be a qualified beneficiary.

Individuals who become entitled to Medicare or who obtain coverage under another group health plan which does not impose a pre-existing conditions limitation or exclusion are ineligible for COBRA. TRS reserves the right to retroactively terminate COBRA coverage if an individual is deemed ineligible.

General Provisions

Continuation coverage for COBRA qualified beneficiaries is identical to the coverage provided to active Benefit Recipients.

COBRA participants may change carriers during the annual Benefit Choice Period or within 60 days of a Qualified Change in Status.

Qualified beneficiaries electing continuation in their own right are enrolled in COBRA under their own Social Security number.

COBRA Notifications and Enrollment

Initial Notification

Initial notifications are provided to all new annuitants and survivors. The notification is to acquaint these individuals with the COBRA law, notification obligations and possible rights to COBRA coverage if loss of regular group health coverage should occur. If an initial notification is not received, contact TRS.

Notification of Eligibility After a Qualifying Event

Notification must be given to TRS within 60 days of the date of the event or the date on which coverage would end, whichever is earlier.

Enrollment Period

Individuals have 60 days from the date of the COBRA notification letter to enroll in COBRA and 45 days from the date of election to pay all currently due premiums. Failure to complete and return the enrollment form or to submit payment by the due dates will terminate COBRA rights. If the enrollment form and required payments are received by the due dates, coverage will be reinstated retroactive to the date of the qualifying event.

Individuals covered under TRIP at the time of the qualifying event may elect COBRA in their own right even if the Benefit Recipient decides not to enroll. If the spouse or dependent children live at another address, notify TRS so that notification can be sent.

Medicare Impact on COBRA

If a Benefit Recipient and/or Dependent Beneficiary Medicare entitlement occurs **before** a COBRA qualifying event, affected qualified beneficiaries are allowed to elect COBRA coverage for the maximum continuation period (see chart on next page).

If Medicare entitlement occurs **after** a COBRA qualifying event, affected qualified beneficiaries are not eligible for COBRA coverage.

Qualifying Events

To be eligible for COBRA, an individual must be enrolled in the group health plan on the day before the qualifying event takes place. A qualifying event is defined as any of the events shown below that cause a loss of coverage.

Duration of COBRA Coverage

Qualifying Events	Continuation Period
Benefit Recipient:	
• Suspension of annuity benefits for any reason, including termination of disability benefits, except for gross misconduct	18 months
• Loss of eligibility	18 months
• Disability Determination by Social Security Administration (SSA) of disability that existed at time of qualifying event	29 months
Dependent Beneficiary	
• Suspension of Benefit Recipient's annunity benefits as stated above	18 months
• Benefit Recipient's death, divorce or legal separation:	
– spouse or ex-spouse, under age 55	36 months
– spouse or ex-spouse, age 55 or older	Until date of Medicare entitlement
• Benefit Recipient's Medicare entitlement	Up to 36 months
• Failure to satisfy the plan's eligibility requirements for Dependent Beneficiary status	36 months
• Disability Determination by Social Security Administration (SSA) of disability that existed at time of qualifying event. Dependent must have been covered by the Benefit Recipient's insurance at the time of the qualifying event.	29 months

COBRA Extensions

Disability Extension

Individuals covered under COBRA who have been determined to be disabled by the federal Social Security Administration (SSA), may be eligible to extend coverage from 18-months to 29-months. Non-disabled family members who are entitled to COBRA are also entitled to the 29-month disability extension.

To be eligible for the extension, an individual must have been disabled during the first 60-days of COBRA continuation coverage and MUST submit a copy of the SSA determination to TRS **within 60 days** of the date of the SSA determination letter and before the end of the original 18-month COBRA coverage period. Coverage will **not** be extended to 29-months if the required documentation is not submitted to TRS within the 60-day period.

The affected individual must also notify TRS of any SSA final determination loss of disability status. This notification must be provided **within 30 days** of the SSA determination letter.

Second Qualifying Event

If a qualifying event resulting in an 18-month maximum continuation period is followed by a second qualifying event, the spouse and/or dependent children may extend coverage up to 36-months.

Waiver of COBRA Rights and Revocation of that Waiver

A qualified beneficiary may waive rights to COBRA coverage during the 60-day election period and can revoke the waiver at any time before the end of the 60-day period. Coverage will not be retroactive to the qualifying event. Waivers and revocations of waivers are considered effective on the date the election is made.

Premium Payment under COBRA

The qualified beneficiary has 45-days from the date coverage is elected to pay all back premiums. Individuals electing COBRA are considered Benefit Recipients and charged the Benefit Recipients rate. A divorced or widowed spouse who has dependent coverage would be considered the Benefit Recipient and charged the Benefit Recipient rate, with the children covered as Dependent Recipients and charged applicable Dependent Recipient rates. If only Dependent Recipient children elect COBRA, each child would be considered a Benefit Recipient and charged the Benefit Recipient rate.

Once the COBRA enrollment form is received and the premium paid, membership is established retroactive to the date coverage was terminated. TRS will mail monthly billing statements to the Benefit Recipient address on file on or about the 10th of each month. Bills for the current month are due by the 25th of the same month. Final notice bills (those with a balance from a previous month) are due by the 20th of the same month.

It is the Benefit Recipient's responsibility to promptly notify TRS **in writing** of any address change and of any billing problems. Failure to pay the COBRA premium by the due date will result in termination of coverage retroactive to the last date of the month in which premiums were paid.

TRS does not contribute to any portion of the premium for COBRA coverage. Most COBRA Benefit Recipients must pay the applicable premium plus a 2% administrative fee for participation. COBRA Benefit Recipients who extend coverage for 29 months due to SSA's determination of disability must pay the applicable premium plus a 50% administrative fee for all months covered beyond the initial 18 months.

Adding Newly-Acquired Dependent Beneficiaries While Enrolled in COBRA

See Chapter 1, Section entitled Enrollment.

Termination of Coverage under COBRA

- **Termination of coverage occurs when the earliest of the following occurs:**
  - Maximum continuation period ends.
  - Benefit Recipient fails to make timely payment of premium.
  - Benefit Recipient or Dependent Beneficiary becomes a participant in another group health plan which does not impose a pre-existing conditions exclusion or limitation (for example, through employment or marriage).
  - Benefit Recipient or Dependent Beneficiary becomes entitled to Medicare. Special rules apply for End-Stage Renal Disease; contact TRS for more information.
  - The TRIP ends.

Conversion Privilege for Health Coverage

Benefit Recipients are eligible to convert to an individual health plan unless group health coverage ended because of:

- Failure to pay the required premium, or
- Coverage is replaced by another group plan, or
- Participant's entitlement to Medicare, or
- Voluntary termination during COBRA coverage.

To be eligible for conversion, participants must have been covered by the current COBRA health plan for at least 3 months and requested conversion within 31 days of exhaustion of COBRA coverage. The converted coverage, if issued, will become effective the day after coverage ended. TRS is not involved in the administration or premium rate structure of insurance benefits obtained through conversion.

See TRS for additional information.

COORDINATION OF BENEFITS

Overview

If a participant enrolled under one of TRIP medical plans is entitled to benefits under another medical plan, the amount of benefits payable under TRIP may be reduced to the extent that the total payment provided by all plans does not exceed the total allowable expenses incurred for the service.

For purposes of Coordination of Benefits (COB), the term "plan" is defined as any plan that provides medical or dental care coverage including the following:

- Any group insurance plan.
- Any governmental plan, except the Illinois Medical Assistance Program (Medicaid) or other state medical assistance program.
- Any "no-fault" motor vehicle plan. This term means a motor vehicle plan which is required by law and provides medical or dental care payments which are made, in whole or in part, without regard to fault. A person subject to such law who has not complied with the law will be deemed to have received the benefits required by the law.
- As required by law.

The term "allowable expense" means any medically necessary covered service for which part of the cost is eligible for payment by this plan.

When two or more plans pay benefits, the TCHP follows the National Association of Insurance Commissioners (NAIC) Model Group coordination of benefit rules for determining the order of benefit payment. This includes use of the Birthday Rule for determining dependent child coverage and the Retiree Rule for determining coverage for laid off or retired employees.

To coordinate benefits under managed care health plans, plan participants should direct questions to the specific plan administrator.

Coordination of Benefits with Medicare

Managed Care Plan–Methods of coordination with managed care and other plans vary. Specific questions should be directed to the individual health plan.

TCHP– For coordination with TCHP, see page 33. For coordination with the Mental Health/Substance Abuse Plan Administrator, see pages 51-52. For coordination with the Prescription Drug Plan Administrator, see page 49.

Medicare Premium

In order to receive the Medicare Primary Premium, participants must be enrolled in both Medicare Parts A and B. If the participant is not enrolled in Medicare Parts A and B, the higher non-Medicare premium will be assessed.

SUBROGATION AND REIMBURSEMENT

Overview

TRIP will not pay for expenses incurred for injuries received as the result of an accident or incident for which a third party is liable. These plans also do not provide benefits to the extent that there is other coverage under non-group medical payments (including automobile liability) or medical expense type coverage to the extent of that coverage.

However, the plans will provide benefits otherwise payable under one of these plans, to or on behalf of its covered persons, but only on the following terms and conditions:

- In the event of any payment under one of these plans, the plan shall be subrogated to all of the covered person's rights of recovery against any person or entity. The covered person shall execute and deliver instruments and documents and do whatever else is necessary to secure such rights. The covered person shall do nothing after loss to prejudice such rights. The covered person shall cooperate with the plan and/or any representatives of the plan in completing such documents and in providing such information relating to any accident as the plan by its representatives may deem necessary to fully investigate the incident. The plan reserves the right to withhold or delay payment of any benefits otherwise payable until all executed documents required by this provision have been received from the covered person.
- The plan is also granted a right of reimbursement from the proceeds of any settlement, judgment or other payment obtained by or on behalf of the covered person. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in the preceding paragraph, but only to the extent of the benefits paid by the plan.
- The plan, by payment of any proceeds to a covered person, is thereby granted a lien on the proceeds of any settlement, judgment or other payment intended for, payable to or received by or on behalf of the covered person or a representative. The covered person in consideration for such payment of proceeds, consents to said lien and shall take whatever steps are necessary to help the plan secure said lien.
- The subrogation and reimbursement rights and liens apply to any recoveries made by or on behalf of the covered person as a result of the injuries sustained, including but not limited to the following:
  - Payments made directly by a third party tort-feasor or any insurance company on behalf of a third party tort-feasor or any other payments on behalf of a third party tort-feasor.
  - Any payments or settlements or judgments or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a covered person or other person.
  - Any other payments from any source designed or intended to compensate a covered person for injuries sustained as the result of negligence or alleged negligence of a third party.
  - Any Workers' Compensation award or settlement.
- The parents of any minor covered person understand and agree that the TCHP does not pay for expenses incurred for injuries received as a result of an accident or incident for which a third party is liable. Any benefits paid on behalf of a minor covered person are conditional upon the plan's express right of reimbursement. No adult covered person hereunder may assign any rights that such person may have to recover medical expenses from any tort-feasor or other person or entity to any minor child or children of the adult covered person without the express prior written consent of the plan. In the event any minor covered child is injured as a result of the acts or omissions of any third party, the adult covered persons/parents agree to promptly notify the plan of the existence of any claim on behalf of the minor child against the third party tort-feasor responsible for the injuries. Further, the adult covered persons/parents agree, prior to the commencement of any claim against the third party tort-feasors responsible for the injuries to the minor child, to either assign any right to collect medical expenses from any tort-feasor or other person or entity to the plan, or at their election, to prosecute a claim for medical expenses on behalf of the plan.

  The adult covered persons/parents further agree that in the event they elect to prosecute a claim for medical expenses that any recovery shall not be diminished under any theory of common fund

and that the provisions of this section shall specifically apply hereto. In default of any obligation hereunder by the adult covered persons/parents, the plan is entitled to recover the conditional benefits advanced plus costs, (including reasonable attorneys' fees), from the adult covered persons/parents.

- No covered person shall make any settlement which specifically excludes or attempts to exclude the benefits paid by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by a covered person, which right shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine" or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No covered person under the plan shall incur any expenses on behalf of the plan in pursuit of the plan's rights to subrogation or reimbursement, specifically, no court costs nor attorneys' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine" or "Attorney's Fund Doctrine."
- The plan shall recover the full amount of benefits paid hereunder without regard to any claim of fault on the part of any covered person, whether under comparative negligence or otherwise.
- The benefits under this plan are secondary to any coverage under no-fault, medical payments or similar insurance.
- This subrogation and reimbursement provision shall be governed by the laws of the State of Illinois.

CLAIM APPEAL PROCESS

Overview

Under TRIP there are appeal procedures to follow when dissatisfied with a claim determination.

Initial Review of Claim Determination

A TCHP plan participant who believes an error has been made in the benefit amount allowed or disallowed must contact the plan administrator within 180 days of the date of the initial claim determination.

A customer service representative will be able to provide more information regarding the denial. In some cases, additional information such as an operative report or x-rays may be required to determine if additional benefits are available. In some cases, a special review by a physician or dentist may be warranted. Each case will be analyzed and considered on its own merits.

If dissatisfied with the outcome of the review, plan participants are entitled to file a grievance or appeal. Contact the plan administrator for information on the procedure. **The plan administrator's internal review process must be used to the fullest extent prior to contacting the CMS/Group Insurance Division regarding a final determination.**

Managed Care Plan Appeal Process

If enrolled in a managed care plan, call your managed care plan or consult the plan's Summary Plan Description or Subscription Certificate for appeals process information.

Final Claim Determination

If, after the plan administrator's review a plan participant still feels that the claim determination is not in accordance with the published benefit coverage, a Final Determination by the CMS/Group Insurance Division may be requested within 60 days of the date of the Initial Review determination. The request must be in writing from the plan participant and be accompanied by all medical documentation supporting the reasons for reconsideration of the benefit determination.

Submit Documentation to:

CMS/Group Insurance Division
Room 600, Stratton Office Building
Springfield, IL 62706

Appealing the Final Claim Determination

If a plan participant is still not satisfied, an appeal of the Final Determination may be made to an appeal committee within 60 days of the Final Review determination. This committee will review the documentation and facts presented in the Final Determination.

The appeal committee will consider the merits of each individual case. If new information is presented to the committee which was not presented during the Final Determination, the appeal will be returned to the CMS/Group Insurance Division for review and reconsideration of the determination.

Plan participants will be notified in writing of the outcome of the committee's review. The decision of the appeal committee shall be final and binding on all parties.

Submit Documentation to:

CMS/Bureau of Benefits
Room 616, Stratton Office Building
Springfield, IL 62706